Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: HARRIS METHODIST FORT WORTH 3255 W PIONEER PKWY ARLINGTON TX 76013-4620	MFDR Tracking #:	M4-07-5741-01
Respondent Name and Box #: American Protection Insurance Box #: 21		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We ask that you review this claim at the Medicare allowable plus 125% of the Medicare allowable, as we feel that this is 'fair & reasonable' amount for this claim"… "We respectfully ask that you reprocess this admit at the 125% of the Medicare allowable."

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $856.75
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Briefly summarized, the Respondent has developed and consistently applies a methodology to determine a fair and reasonable reimbursement amount to ensure that similar procedures provided in similar circumstances receive similar reimbursement."… "Regardless of the methodology employed by the Respondent to ensure a fair and reasonable reimbursement, the burden remains solely upon the Requestor to show that the amount it seeks is fair and reasonable. The Requestor has failed to meet its burden."… "Even though the Requestor may bill its usual and customary fee, it is due only those monies that are fair and reasonable."… "Respondent asserts it paid a fair and reasonable rate to the Requestor for the surgery. Requestor has failed to demonstrate the amount of reimbursement it seeks is fair and reasonable in accordance with the Act. No additional reimbursement is warranted."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/19/2006	W1, W3, 45, 47, 62, 113, 147, 900, 968, 080-001, 112-003, 113-011, 113-031, 113-035, 910-049, 960-001, 983-001	Emergency Room Visit	$856.75	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - W1 – "Workers' Compensation State Fee Schedule Adjustment $0.00"
   - W3 – "Additional payment made on appeal/reconsideration."
   - 45 – "Charges exceed your contracted/legislated fee arrangement."
     - "The charges have been reviewed by FairPay Solutions Inc. For questions regarding this analysis, contact FairPay Solutions Customer Service 888-380-5616."
     - "D01 The reimbursement for this line item has been included in the payment recommendation(s) for all covered services which are reported on another line or lines"
     - "S01 Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area."
     - "S04 This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed."
   - 62 – "Payment denied/reduced for absence of, or exceeded, pre-certification/authorization."
   - 113 – "Any other reduction was determined by the external vendor."
   - 147 – "Provider contracted/negotiated rate expired or not on file."
   - 900 – "Based on further review, no additional allowance is warranted."
   - 968 – "This service has been reviewed per claim representative."
   - 080-001 – "Review of this bill has resulted in an adjusted reimbursement for the entire bill of $0.00"
   - 112-003 – "The primary provider is a non-contracted provider."
   - 113-011 – "Other import re-pricing completed by FairPay"
   - 113-031 – "Export/import re-pricing explanation1:"
     - "D01 The reimbursement for this line item has been included in the payment recommendation(s) for all covered services which are reported on another line or lines"
     - "S01 Pursuant to Texas Labor Code 413.011 and other applicable statutes this bill has been reviewed to a standard of reasonableness based on current industry benchmarks of typical reimbursement for comparable services in your geographical area."
     - "S04 This item is packaged or bundled into another basic service or surgical procedure fee performed on this date of service, additional reimbursement disallowed."
   - 113-035 – "Export/import re-pricing explanation 5: The charges have been reviewed by FairPay Solutions, Inc. For questions regarding this analysis, contact FairPay Solutions Customer Service at 8888-380-5616."
   - 910-049 – "Payment denied/reduced for absence of, or exceeded, pre-certification/authorization."
   - 960-001 – "Repricing per Fair Pay Solutions. For Questions Call 888-380-5616
   - 983-001 – "Upon further review-additional payment is warranted."
2. This dispute relates to an outpatient emergency room visit including diagnostic radiological services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. Division rule at 28 TAC §133.307(c)(2)(A), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "a copy of all medical bill(s)"… "as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter"… This request for medical fee dispute resolution was received by the Division on May 4, 2007. Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(A).
5. Division rule at 28 TAC §133.307(c)(2)(C), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division"… Review of the documentation submitted by the requestor finds that the documentation does not support that all the services in dispute were rendered on the dates of service listed on the requestor's *Table*. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(C).

6. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, and applicable to disputes filed on or after January 15, 2007 requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not completed the required sections of the request in the form and manner prescribed by the Division as required by Division rule at 28 TAC §133.307(c)(2)(F)(iii).
7. Division Rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, and applicable to disputes filed on or after January 15, 2007, 31 TexReg 10314, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable". The requestor's position statement asserts that "We ask that you review this claim at the Medicare allowable plus 125% of the Medicare allowable, as we feel that this is 'fair & reasonable' amount for this claim." Review of the requestor's documentation finds that the requestor did not discuss or demonstrate how payment in the amount of 125% of the Medicare rate would yield a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Review of the submitted documentation finds that the requestor has not discussed, demonstrated or justified that the amount sought is a fair and reasonable rate of reimbursement sufficient to meet the requirements of 28 TAC §133.307(c)(2)(G).
8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(C), §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.250, §133.307, §134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.